COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS CLAIMS
CLAIM NO. _____
BEFORE _____

_____ PLAINTIFF
(EMPLOYEE)

V.S. **AFFIDAVIT REGARDING REHABILITATION SERVICES**

_____ DEFENDANT(S)
(EMPLOYER)

_____
(**OTHER DEFENDANTS)**

_____
(**SPECIAL FUND)**

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The undersigned, _____ after being duly sworn,
(NAME)
states that on _____, the undersigned sustained a work-related
(DATE)
injury at
_____.
(BUSINESS NAME AND ADDRESS)

Notice was given on_____
to_____.
(DATE) **(PERSON AND POSITION)**

An employment relationship existed between the _____ and the
(EMPLOYEE)

employer in this action.

Medical treatment was provided on _____ and given by _____
(DATE) **(MEDICAL PROVIDER &**

_____. The medical report of Dr. _____
ADDRESS) **(DOCTOR'S NAME)**

is attached which shows my restrictions and medical ability to engage in retraining.

The employee/plaintiff requests that:

? An evaluation be performed to determine possible areas of retraining**.**

? Rehabilitation training be ordered in the area of _____
(OCCUPATION)
and the training be conducted at_____
(FACILITY)
at a cost of $ _____ plus estimated travel expenses of
(COST)
$_____. The estimated length of the training is _____ weeks.
(COST) **(WEEKS)**
Documentation from the training facility and costs involved are attached. This training program is

accredited by_____.
(NAME & ADDRESS OF ORGANIZATION WHICH ACCREDITS PROGRAM)

The immediate provision for rehabilitation services will substantially increase the probability that

the employee\plaintiff will return to work.

_____

(EMPLOYEE'S SIGNATURE)

Subscribed and sworn to before me by _____

(EMPLOYEE'S NAME)

on this the _____ day of _____ 20 _____.

(MONTH) **(DATE)** **(YEAR)**

_____

NOTARY PUBLIC

My Commission expires: _____ County: _____